California Department of Alcohol and Drug Programs
Co-Occuring Disorders Unit – http://www.adp.ca.gov/COD

Planning Guide for Prevention and Early Intervention (PEI) under the Mental Health Services Act (MHSA)

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Executive Summary

The PEI Planning Guide will assist providers in the alcohol and other drugs (AOD) field in understanding the requirements of the PEI program within the MHSA. With this information, programs will be better able to participate effectively in the local PEI planning process and compete for MHSA funding for PEI services.

SAMHSA's TIP 42 states that, ". . . substance abuse treatment programs typically reported that 50 to 75 percent of their clients had Co-Occurring Disorders (COD), while corresponding mental-health settings cited proportions of 20 to 50 percent." If there is truly no wrong door, our field needs to take advantage of this opportunity to ensure that it is able to address the mental health needs of its clients.

This guide begins with an overview of the MHSA, which explains the Act's intent and moves on to a description of the PEI planning process. The PEI component of the Act provides a unique opportunity for substance abuse providers to access MHSA funding.

The PEI component specifically funds services that are designed to prevent the the development or worsening of a mental illness or serious emotional disturbance. **PEI funding is not restricted to services just for the Seriously Mentally Ill (SMI), as is the case with the other components of the Act. As a result, substance abuse providers could access funding for services they provide to clients and their families, to the extent that these services prevent the *development or worsening* of mental illness within at-risk populations.**

(The definitions of and distinctions between "prevention" and "treatment" under PEI are further discussed in the "**PEI Program Self-Assessment: How Your Program Could Work in Your County**" section.)

The "PEI Programs – Self-Assessment and Fitting In: How Your Program Can Work in Your County" section demonstrates how programs may evaluate their capability for providing PEI services. Additionally, this section provides further information on PEI requirements with specific examples of likely PEI treatment and prevention services in which substance abuse providers hold experience and expertise.

Finally, the PEI Proposal Framework provides information about the PEI planning process. This information is based on the elements typically required in requests for proposals (RFP). The Framework will be a useful model in program design and planning, regardless of whether a particular element is contained in a county's RFP or whether an RFP is organized in the same structure as the Framework.

It is imperative that substance abuse providers participate in the local PEI planning processes. Within the framework established by the Mental Health Services Oversight and Accountability Commission (MHSOAC), counties are working now to establish priority services and populations for PEI funds. Substance abuse programs offer a unique vehicle for local mental health systems to reach priority population with services that are proven effective.

The MHSA Overview

The MHSA resulted from the ballot passage of Proposition 63 on the November 2004 ballot. The measure is intended to expand the availability of mental health services, provide innovative programs based on proven strategies, improve access to services for underserved populations, and provide prevention services that help people get care before a mental illness becomes disabling.

Funding is derived from a one-percent tax on personal income over one million dollars. All MHSA funding may only be used for new or expanded services, which means there may be "no supplantation" of funding for existing services.

The MHSA established the MHSOAC, which is the oversight body responsible for review and approval of local plans.

Major priorities of the MHSA are:

- ✓ transforming the mental health system in California,
- ✓ increasing the availability of community based services,
- ✓ adding PEI services, and
- ✓ addressing disparities in access to mental health services.

PEI services play an important role in the transformational component of the MHSA. The complete text of the MHSA is in Appendix I.

"Just like they say, no kids are left behind but yet here we are – left behind."

Urban young adult

"Go in search of people. Begin with what they know. Build on what they have."

Chinese proverb

PEI Overview

After a comprehensive county-level planning process, PEI services are funded by the state at the county level. The county submits a proposed plan to the Department of Mental Health (DMH) for review and comment. After DMH review, plans then go to the MHSOAC for review and approval.

Across the state, county mental health and behavioral health systems are in various stages of developing and implementing PEI plans under the MHSA.

Within the MHSA context, "prevention" has a different meaning than in the AOD field.

Mental health prevention seeks to prevent mental illnesses from becoming severe and disabling by:

- ✓ reducing risk factors or stressors,
- ✓ building coping skills and
- ✓ increasing connections and supports.

Fifty-one percent of all PEI funding must go to services for those under age 25, for two age groups: 0-15 and 16-25. The remaining 49% of PEI funds must address all age groups, separated into two: 26-59 and 60+. Counties with a population below 200,000, however, are exempt from this requirement.

In addition, five percent of PEI funding is to be allocated for **Innovative Programs**. Guidelines defining innovative programs are still under discussion by the MHSOAC. Under the general provisions of the MHSA, however, innovative programs must:

- ✓ increase access to underserved populations,
- ✓ increase the quality and outcomes of services,
- ✓ promote interagency collaboration, and increase access to services.

Innovative practices could include introduction of new approaches, transformation of an existing approach, expansion of locally tested successful approaches, or adaptation of a successful practice for new populations.

Prevention has a long history as a discipline within the AOD field. AOD prevention advocates argue that their adoption of evidence-based practices, logic models and a general orientation to outcomes has led the field's movement in these areas.

The AOD field has developed an extensive body of knowledge regarding the behaviors and conditions that are precursors to AOD problems at the individual and community level. In addition, there are a number of best-practices models with proven outcomes that can effectively impact these conditions and behaviors.

Conversely, prevention has not played a large role in the mental health field. Previously, the primary goal of the state's mental health system was to provide services to meet the needs of the severely and persistently mentally ill and seriously emotionally disturbed caseload, generally through *treatment*.. Now *prevention* is an additional goal.

The rigorous planning framework for PEI services and the emphases on community collaboration, cultural competence, underserved communities, resilience and recovery, and outcomes-based program design are familiar operational concepts to AOD providers.

Planning Process Participation

Both DMH and MHSOAC issued comprehensive parameters for PEI services as well as guidelines for the local planning process.

Each county, however, is conducting its own planning process that incorporates local needs, services and values in addressing PEI requirements.

Each county sets up its own rules and procedures for the planning process and the subsequent issuing of PEI RFPs for the program services in the plan.

As soon as possible, set up a meeting with the local parties in your county's mental health or behavioral health department.

- ✓ **Introduce yourself and your program.**
- ✓ **Find out about special local rules and procedures for PEI planning.** ***In some counties, planning participants are excluded from RFP bidding.***
- ✓ **Build a relationship!**

PEI plans are under no statewide deadline for plan submission or program implementation. DMH, however, has issued guidelines for a two-year program beginning FY 07-08 through FY 08-09. **Counties are working under a certain amount of time pressure to complete the planning and implementation process** because funds not spent by the end of specified periods will revert to the state. It is unclear whether unspent funds will eventually be returned to the counties.

To date, only one county has submitted its PEI plan to the state. Even if many counties submit plans in the next few months, by the time the approval process is completed there would only be six to eight months left in FY 08-09.

It is important that AOD programs be active participants in the planning process. There are no guarantees, but one has a better chance of being a partner in implementation, if one is a partner in planning. Remember, AOD programs are likely the local prevention experts.

The involvement of consumers and youth as para-professionals, staff and advisory members of committees is also a critical component. **It is critical that planning for programs and projects is collaborative and client driven.** For more information on this process see the MHSA Announcement 07-19 (Appendix 4), Enclosure 1, pages 12 through 15 on the local planning process: http://www.dmh.ca.gov/DMHDocs/docs/notices07/07_19_Enclosure1.pdf

Remember, AOD programs are likely the local prevention experts.

Participation in the planning process will also help develop a broader understanding of local mental health needs and priorities. In some counties, suicide prevention might be a top priority for. In others, the priority might be mitigating trauma.

To prepare a solid proposal it is essential to learn local PEI priorities and participate in the development process.

A good resource is a monthly conference call[1] hosted by DMH for county mental health staff and their partners in PEI plan development. The purpose of the call is to answer questions related to PEI guidelines.

Participation in these conference calls will help build the knowledge-base that will be the foundation of a successful proposal.

PEI Planning Matrix **(See next page for explanation)**

PRIORITY POPULATIONS ▼	COMMUNITY MENTAL HEALTH NEEDS				
	Disparities in Access to MH Services	Psychosocial Impact of Trauma	At-Risk Children, Youth & Young Adults	Mental Illness Discrimination and Stigma	Suicide Risk
Underserved Cultural Populations	**Student Asst. Programs (SAPs)** **Mentoring** **Youth Development–FNL**	**Older Adult MH & AOD Screening**	**SAPs** **Mentoring** **Youth Development–FNL**	**Older Adult MH & AOD Screening**	**Suicide Prevention in AOD Tx** **Older Adult MH & AOD Screening**
Individuals with Onset of Serious Psychiatric Illness			**MH Staff at AOD Tx**		
Children/Youth in Stressed Families	**Drug Court and Proposition 36 Support**	**Counseling for Domestic Violence Clients, Family** **Housing Asst. to post-AOD Tx Parents**	**SAPs** **Mentoring** **Youth Development–FNL**	**Drug Court and Proposition 36 Support**	
Trauma-Exposed Individuals	**MH Staff at AOD Tx**	**MH Staff at AOD Tx**	**Counseling for Domestic Vio. Clients, Family**	**MH Staff at AOD Tx**	
Children/Youth at Risk for School Failure	**Youth Development–FNL** **SAPs**	**Counseling for Domestic Violence Clients, Family** **SAPs** **Mentoring**	**SAPs** **Mentoring** **Youth Development–FNL**		
Children & Youth at Risk of, or Experiencing, Juvenile Justice Involvement	**SAPs** **Mentoring** **Youth Development–FNL**	**Counseling for Domestic Vio. Clients, Family** **SAPs** **Mentoring**	**SAPs** **Mentoring** **Youth Development–FNL**		

Fig. 1 – With specific examples of programs (please see detailed explanations of these in the ADP Suggested Strategies, Appendix 1) inserted into the framework

[1] As of April 2008, these are held on the second Wednesday of each month from 9:00 a.m. to 10:00 a.m. The phone number is 877-536-5793 and the participant code is 528094.

PEI Program Self-Assessment: How Your Program Could Work in Your County

The statewide PEI implementation plan is based on a framework of overarching service needs and priority populations. The basic structure is shown in Figure 1 on page 6.

As you can see from the *examples* in the cells of the planning matrix, opportunities clearly exist for AOD programs.

A first step in self-assessment is to look at your current programs with regard to their fit with the statewide MHSA priority needs and populations. (See preceding and subsequent pages.)

For more examples please see the ADP Suggested PEI Strategies document (Appendix 1), http://www.adp.ca.gov/COD/pdf/PEI_Strategies.pdf). Note that the intersections of some Community Mental Health Needs – **Trauma**, **At-Risk** groups and **Mental Illness Discrimination and Stigma** – for the **Priority Populations** are most commonly served by AOD prevention and treatment providers.

Many priority populations in the PEI process are frequently involved in AOD treatment caseloads. Additional guidance is provided in the PEI-focused issue of the ADP's *COD E-Circular* (Appendix 7), Vol. 1, Issue 1 - COD E-Circ. - PEI The

...the process is not constrained to creating programs that fit into single cells of the matrix. Ideally, every program could serve multiple populations and address multiple needs.

county planning process will narrow the choices and most likely focus on a limited set of needs and services that best address local priorities. Priority areas will ultimately be established locally and not every cell in the matrix will represent an actual funded program.

In addition, the process is not constrained to creating programs that fit into single cells of the matrix. Ideally, every program could serve multiple populations and address multiple needs. **The better you understand your county's mental health needs, the better you will be able to respond to the services requested in the county's plan.**

Once your county plan is approved by DMH, the county will issue an RFP for services to meet the plan's requirements.

Prevention or Treatment?

The difference between AOD definitions of "prevention" and "treatment" and the MHSA definitions for those terms can lead to confusion for AOD providers. Keep in mind that, for PEI, these terms are used with a "new" *mental health* meaning, as further detailed below. Additionally, there may be some confusion about how an *AOD* **treatment** *service* to achieve a PEI goal qualifies as *MHSA* **prevention.**

AOD programs should understand that the MHSA's approach to prevention differs from that of substance abuse prevention.

The MHSA/PEI distinctions between prevention and treatment must be used when developing "prevention" services with PEI funding.

Although most services under PEI, are provided *prior to* a mental illness diagnosis, some post-diagnosis treatment services can qualify as either "prevention" or "early

intervention". Early interventions – to **prevent** a mental health problem from getting worse – must generally be of *short duration and low-intensity* (see also **Prevention or Early Intervention?** below).

For mental health purposes, "prevention" is either action that avoids mental illness by eliminating or reducing causative factors or services that substantially reduce the severity of the mental illness.

For example, evidence indicates that AOD use can contribute to mental health problems and exacerbate them. Citing such evidence, a county could offer AOD treatment **to a PEI priority population** who are abusing substances. Under PEI, the county could provide new *AOD **treatment*** or expand eligibility for such an existing program in order to *prevent* worsening of mental problems – even if the PEI program client is already diagnosed with a mental illness and/or substance abuse. In contrast to *AOD prevention*, which occurs only prior to diagnosis, the services provided would be considered *prevention* under MHSA.

Remember programs must be *new* or *expanded* in some way to meet the MHSA requirement of **no supplantation**.

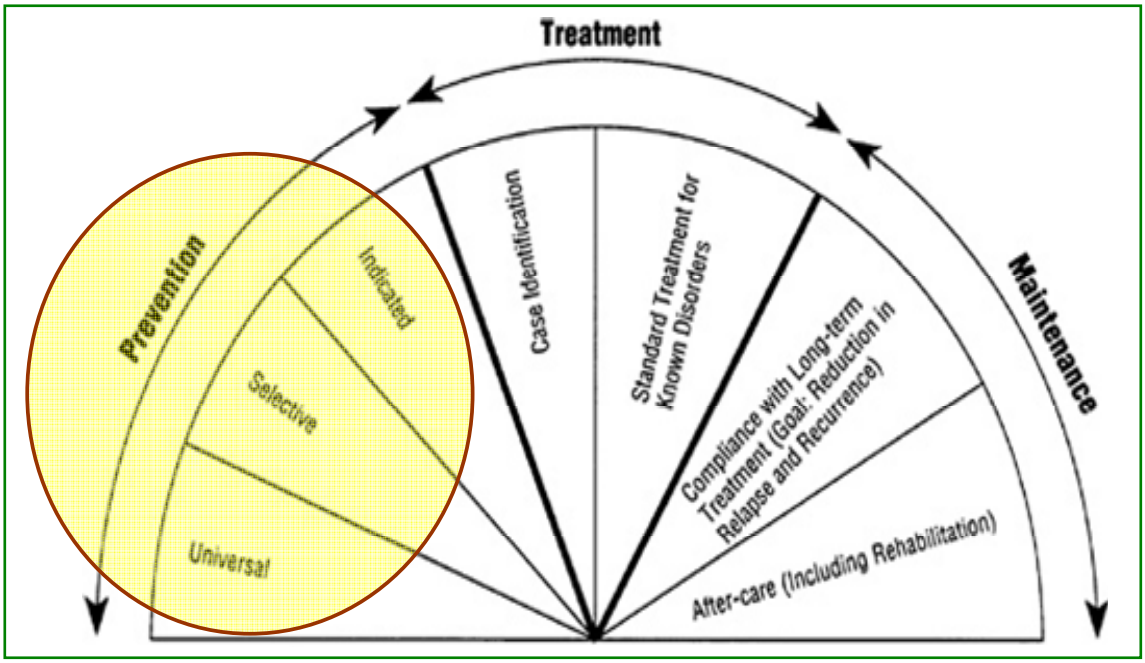
Universal, Selective, or Indicated?

Under PEI, prevention activities may be addressed to three different populations: universal, indicated and selective. This approach, as stated in the PEI guidelines, is based on the Institute of Medicine (IOM) model of focus for services (see Figure 2, below).

Services considered *prevention* under PEI will often serve a **universal** or a **selective** population. For example, a new program that presents drug education in *all* sixth-grade classrooms would be **universal** regardless of individual risk factors.

On the other hand, a **selective** PEI program might offer additional role plays in refusing drugs only to those students at risk of school failure. Such a *selective* program focuses on a population with *a higher risk factor*, in this case, those who

Figure 2 – PEI & IOM Spectrum o Mental Health Intervention



are challenged academically – even if they may be using substances. Under PEI, such services would constitute *prevention* for *mental illness*.

Finally, an example of an **indicated** population would be a *subgroup* of youth in foster care. In general, foster care youth are a *selective* population because they are a traumatized group, due to being removed from their parental home. The **indicated** *subgroup* of these foster youth would be those who specifically screened positive – *an individual risk determination* – for substance use, since their chance of mental illness might be reduced by avoiding further substance abuse.

Prevention or Early Intervention?

Early Intervention for PEI under the MHSA will frequently work with *indicated* or *selective* populations in the IOM service model and is more likely to involve actual mental health-based interventions. For example, screening for depression at a perinatal AOD treatment program might be part of a *selective* Early Intervention program.

In the case of individuals experiencing the early onset or early signs and symptoms of mental illness, such as post-traumatic stress disorder (PTSD), MHSA Early Intervention will generally focus on low intensity and/or short duration services.

Get Involved *Now!*

Again, participation in the local PEI planning process is essential to learning the approaches that are evolving in local plans. Participation will allow you, as a stakeholder, the opportunity to provide input. Look for **gaps** in the services that planned programs and proposals provide for the priority needs and populations of your county. Are there AOD programs you can suggest to fill these gaps?

What Programs Work for PEI?

An examination of the planning matrix (Figure 1, page 6) shows that AOD programs can be particularly well suited to address certain combinations of PEI priority populations and community needs. Where might your program's skills and experience fit into the matrix? Are these areas that are a priority to your county?

By being involved with the planning process *now*, you will be in a position to work with partners, collaborating groups, and other agencies in advocating for the programs you view as needed. Once the county plan is approved, the county will most likely issue an RFP for each of the programs called for in the plan.

A first step in self-assessment is to compare how your current programs fit within the statewide MHSA priority needs and populations.

- ✓ Which PEI priority population is presently in your caseload?
- ✓ How many are they?
- ✓ How do your current services address PEI needs?
- ✓ Do existing programs need modification to meet PEI needs?
- ✓ Would this modification be an enhancement or a significant re-design of your program?
- ✓ What gaps need filling?
- ✓ Will any modification require only specialized staff or an entirely new program?

An Overview of AOD Programs in PEI

Youth Treatment – Many programs providing prevention or treatment services to youth could be competitive for PEI. While only a few ADP-licensed or certified treatment programs serve those under age 18, they and prevention providers are still in a good position to identify AOD risk factors and, possibly, to provide youth intervention services. Important collaborative partners include schools, juvenile justice agencies, and civic and community organizations.

A more complete and detailed listing of suggested kinds of programs and services that are well positioned to compete for PEI funding is contained in the ADP Suggested PEI Strategies documents; http://www.adp.ca.gov/COD/pdf/PEI_Strategies.pdf

Children's Services – This is a potential priority population for children present with their mothers in AOD perinatal treatment programs. AOD prevention – and possibly even treatment – programs might successfully collaborate with Children's Protective Services and Drug Courts to propose PEI programs for this group.

These children are clearly a high risk group in stressed families often exposed to trauma.

Student Assistance, Mentoring and Youth Development – These programs are optimally situated to intervene with youth at risk for school failure. Assessment can often identify past trauma, substance abuse, suicide risk and juvenile justice involvement.

Friday Night Live (FNL) programs are an example of a **Mentoring, and/or a Youth Development** program.

FNL exists in 56 counties and is open to collaborations with prevention and treatment providers as well as civic groups and government bodies interested in expanding programs current services with PEI funding

Important collaborative partners could include schools, juvenile justice agencies, and civic and community organizations.[2]

[2] For a more complete and detailed listing of suggested kinds of programs and services that are well positioned to compete for PEI funding see the ADP documents in Appendices 1 and 7 and the MHSA PEI documents in Appendix 4, especially Enclosure 6, "Resource Materials").

PEI Proposal Framework

Each county is conducting its own planning process. The priorities, programs and provider solicitation methods will be guided by the county. Once counties plans are approved, the counties will likely issue RFPs for services in their plans.

The proposal framework is based on elements typically required in RFPs. This framework will be useful in program design and planning *in response to the county RFP* regardless of whether a particular element is contained in a county's RFP or whether an RFP is organized in the same structure as in this framework.

Proposal Framework Components

The description of proposals components will help guide your proposal writing and also serve as a basis for further self-assessment and refinement during the proposal development process. After sitting in on all those planning meetings, and providing feedback on the direction and content of the county's PEI plan, you will *not* want to submit a proposal that falls short!

Some components may be written with standard proposal language. Others may require thought and analysis by program managers, staff and clients.

Statement of Need

In this section applicants are generally asked to define the risk factors that they will address in their program, based on the needs identified by the local PEI planning process.

You must *tailor* your proposal to the county's RFP guidelines and description.

This framework will be useful in program design and planning *in response to the county RFP* regardless of whether a particular element is contained in a county's RFP.

Target Population

In the RFP, the desired program participants hold particular qualities, e.g., demographic, clinical, geographic, socio-economic, risk, resiliency and other special characteristics. Your proposal must specifically address how you will serve these populations.

Ask the following questions to align your proposal:

- ✓ Do you presently serve and/or access the populations identified in your county plan?
- ✓ Can you identify where they come from and why they come to your program?
- ✓ Are they a homogenous population or are they segmented into groups?
- ✓ Make sure you represent your clients as real people, and not just statistics. Use unidentified case studies if needed.

Nature of the Problem

- ❖ **Clearly demonstrate your understanding of the problem as it exists within your caseload and your community. Incorporate relevant incidence or prevalence data, preferably local, that documents the existence of the problem.**
- ❖ Identify **community resources** that address the described problem and **how you will intersect with them**.
- ❖ **Identify the gap** between the problem level and available resources.

- Describe **the current, "no-program" baseline** for the issue you are proposing to work on, what the situation is *now*. Provide a quantitative description of the problem. This baseline will be the foundation for outcome measurement in your program.
- **Consider providing some population numbers**. How many of the people described above experience a problematic condition or behavior? How many of them will your program commit to serving?

The Role of Data

To the maximum extent possible, establish your credibility with descriptions of the target populations, compare them to your client base, and describe the problems they experience using local data. Few statements better reveal a program's lack of knowledge or experience in working with a target population than sentences that begin like, "Many studies show that ...", or "Co-occurring disorders are a significant problem in our community." National or statewide studies help set the stage, but **you must demonstrate that you know the local situation in a detailed, quantitative manner**.

Few statements better reveal to a proposal reviewer that the funding applicant does not know the problem than sentences that begin like, "Many studies show that . . .", or "Co-occurring disorders are a significant problem in our community."

Qualitative data from surveys, focus groups or other ethnographic approaches adds further dimension to the quantitative data. The reality frequently is that good local data on specific problem areas like the number of persons who experienced trauma or the numbers of homeless youth simply may not be reliable or available. In cases like this, being able to say that *x* percent of your current client base is at-risk of, or has been exposed to trauma, will help bridge the gap.

To the maximum extent possible, the descriptions of your client base and the problems they experience should be supported by local data.

It is not the applicant's responsibility to definitively identify the total numbers of people in any of the PEI priority populations. The county will do this within its plan and RFP. Be sure, however, to note in the RFP the expectation of –

- ✓ how many clients the program will serve and
- ✓ how many will experience lasting benefit as a result.

Proposed Services: Implementation and Description

At this phase, it is critical that program proposals reflect the following important considerations:

1) **Under PEI, as with all MHSA services, existing programs are subject to the non-supplantation requirement**. Funding is not permitted for programs that are already in existence, even in prevention, unless they are expanded or modified to meet specific local PEI priorities. Programs should build on existing expertise and experience with focus populations. It is important to examine how new collaborations with mental health providers could be built.

2) Similarly, it is important that clear limits **distinguish PEI from programs funded under the MHSA Community Support Services component**. *Prevention* funds must be used prior to a diagnosis and not for prevention of a mental illness relapse. *Early Intervention* funds must be used in the very early manifestation (onset) of a mental illness. This is where the guidelines separate PEI from treatment.

3) **Leveraging in-kind resources and existing expertise is strongly emphasized within the PEI component**. Programs should be prepared to bring something to the table, e.g., staff, facility space and other resources paid with other funding sources.

4) **Partnerships and collaboration with other organizations, facilities, agencies, and community populations are essential to successful PEI programs.** The California Department of Alcohol and Drug Programs' (ADP) cover letter to, "ADP Suggested PEI Strategies," in Appendix 1, provides a number of suggestions for likely collaborators. Also see *Community Partners* on the next page.

Are there cost, caseload, outcome or other considerations that set you apart from other providers of the same service?

Your Product

What is the program or service that you will employ in order to achieve specific client outcomes?

Key elements of the program

- ✓ What program aspects or activities are crucial to achieving outcomes?
- ✓ What is the logic model that forms the foundation for the proposed program services?

Comparative advantage

- ✓ Why are the services *you propose* a better investment than other alternatives?
- ✓ What cost, caseload, outcome or other considerations set you apart from other providers of the same service?

Outcomes

- ✓ What client outcomes are expected?
- ✓ How are these measured and verified?
- ✓ What gains are typically made by clients during participation in the program?
- ✓ Can these be represented as milestones?

Scope, duration and intensity

- ✓ How much, how long, how intensive is the program?
- ✓ Are there different tracks based on client need or other characteristics?

Engagement and Retention

Even the best service model can't work if people don't stay in the program.

What are specific actions taken to:

- ✓ attract clients to the program, and
- ✓ keep them involved long enough to experience the intended benefit?

Efficacy

- ✓ What is the evidence base for the efficacy of these approaches?

Overall, how do the above service characteristics come together in a unified program design that will achieve specific PEI outcomes?

Community Partners

As mentioned previously, using partnerships and collaboration is a key principle of PEI. Referrals and linkages are another aspect of such partnerships.

- ✓ How will you use other community resources in providing the services proposed?
- ✓ What is the essential contribution they will make to the program?
- ✓ How are program performance and client outcomes enhanced through these partnerships?
- ✓ If needed, how will multi-agency service plans be developed and coordinated?

The PEI priority population(s) you serve may well be multi-system clients. Documentation of partnerships will require more than a simple letter of support.

COD Services and PEI

Contrary to what you might expect, many of the MHSA PEI programs for which AOD service providers offer programs will *not* be addressing COD.

For example, *AOD treatment* services provided to the parents of children at risk of foster care, in an effort to *prevent* the children's trauma of separation from their parents, would not be considered COD services. Rather, these types of services would be considered *prevention* under PEI because they are designed to prevent *trauma* to the children, which is a risk factor for mental illness.

A COD component could be an important part of your services. Be sure, however, that you base your proposal on the RFP guidelines. COD services may be a possible, and relatively simple, addition in many programs if the services are designed to *prevent* the development or worsening of a mental illness.

Note: in this context the PEI definition of *prevention* is applicable. You must understand this distinction *and clearly specify how the services you offer fall within MHSA prevention or early intervention.*

- ✓ How will you screen and assess clients for the presence of COD, substance use and abuse accompanied by mental disorders?
- ✓ How does the RFP propose that you use the information obtained from screening and assessment to develop appropriate approaches for COD clients?

Include how the screening will lead to appropriate referrals. Additionally, specify the linkages that the agency has or will establish with "treatment providers."

The screening or assessment instructions should include how the screening will lead to **appropriate referrals**. Additionally, specify the **linkages** that the agency has or will establish with "treatment providers."

Implementation Timelines

- ✓ If this is a new or modified program, what is the timeframe for implementation?
- ✓ How long will it take to start services?
- ✓ What are the key milestones in getting the program off the ground?
- ✓ What obstacles are likely to occur?
- ✓ What is your strategy for minimizing their impact?

Client Focus

Another PEI principle is client-driven programs.

Staff working directly with participants is the prime producer of results for any program. (See next page.)

- ✓ How is consumer input used in program planning, implementation and evaluation?
- ✓ How are the characteristics of the focus population, which you discussed previously, considered in providing services to that group?

Evidence-Based Practices

Proposed services must document the basis for considering their standardized program practices as evidenced-based, whether through national studies or local experience.

The MHSOAC, in its PEI "Proposal Review Tool."[3] contains criteria for rating the extent to which programs "...are likely to achieve selected outcomes based on research evidence, promising practices or locally proven practice."

Some specific aspects to consider in discussing the evidence supporting the services you propose are:

- ✓ Why did you select this particular evidence-based practice (EBP) over other EBPs?
- ✓ If it is a "promising" or "locally proven" practice, why did you choose this intervention over others?
- ✓ What evidence exists that indicates that the practice you propose is appropriate for the outcomes you want to achieve?
- ✓ What is the evidence that documents that this practice is effective with the target population?
- ✓ If the evidence is limited or non-existent for the target population, what information can you provide to support the selection of the intervention for the target population?

Evidence-Based Practices

Program models based in research provide the most rigorous evidence base to support them.

❖ Your model validation may be based on research conducted with a population that differs in important ways from the one you are proposing to serve.

❖ To better address cultural, clinical or other characteristics of your target population, adjustments to the model may be required.

- Will you be making any modifications to the evidence-based practice on which program services are based?
- What is the basis for making these adjustments?
- Will fidelity to the model be compromised?
- What is the anticipated impact on client outcomes?
- How will you document the efficacy of these modifications?

[3] Please see Appendix V. While this instrument is intended for use in reviewing county-level plans, it will helpful to agencies proposing services within those plans.

Organizational Background and Staff

✓ Staff

Staff working directly with participants is the prime producer of results for any program. The right staff is just as important as the right program. Both staff turnover and poor matching of staff skills to clients' needs reduce results; the presence of committed, skilled and energetic people makes the difference!

Explain how your staff will make the program a success:

- How do the qualifications, experience, and other characteristics of the staff correspond to client diversity and clinical needs?
- Are they qualified to deliver the proposed services in terms of licensure or certification?
- How many hours of each position is allocated to the proposed program?

✓ Agency History as a Service Provider

- How is your program uniquely positioned in the community in terms of access to clients, track record in providing the required services, and credibility as a community resource?
- How do the services you currently provide correspond to local program/ caseload priorities?
- If you are not already dealing with a priority population and providing the required services, will this modification be a natural evolution for your organization or a big change in mission?
- Are you ready, willing and able to succeed in this new service arena?
- Is the facility ADA compliant?

How are you uniquely positioned in the community in terms of access to clients, track record in providing the required services, and credibility as a community resource?

✓ Board of Directors

- Is the composition of the Board representative of the population your program proposes to serve?
- Are Board members well connected to the community served?
- What, as individuals, do they contribute to the organization's –
  - grassroots authenticity?
  - fundraising horsepower?
  - professional expertise (legal, medical, accounting, etc.)?
  - influence in the community?

How are effective use of staff time and other operational efficiencies specifically connected to program performance?

Program Evaluation

✓ Program Performance

- From both a quantitative and a qualitative perspective, how do you measure and manage measure key program processes?
- How are these processes specifically connected to program performance? An example is the use of a model like

NIATx, which shows **effective use of staff time and other operational efficiencies**.

✓ **Client Outcomes**

- How do you measure the client response to services?
- What are the key changes in client condition or behavior that document success?
- How are these measured over time in the process of program participation?
- How are they measured after the period of active participation/intervention ends?

✓ **Program Supervision and Oversight**

- Beyond ensuring that service units are provided in accordance with contract requirements, what are your methods for managing service quality?
- What are procedures for supervising staff at the service delivery level?.
- How do you staff training needs identified?

✓ **Data**

- How will you collect, record, analyze and report data on program performance and client outcomes?
- How are these data used to manage the program and support quality management?
- What are the tools used for information storage, retrieval and analysis?

✓ **Feedback Loop**

- How do program managers identify and respond to quality issues relating to program performance or client outcomes?
- How are front line staff and program participants involved?
- What is the feedback loop to the program?
- How do you use this information to improve services?

✓ **Consumer Involvement**

- How will consumers be involved in evaluating program performance and their own outcomes?
- What methods are employed to involve consumers?

Cost and Other Quantitative Elements

✓ **Budget**

- Be prepared to identify and justify line item costs for the proposed program. Please see the Sample Budget and Services plan in Appendix 6 for one approach to presenting the quantitative aspects of your program.

✓ **Staffing**

- How many FTEs will be allocated for each position?
- How many staff provide direct client service?

✓ Program **Participants**

- How are you prepared to serve the "unduplicated number of program participants" called for in the RFP?

✓ **Service Units**

- List those program activities that you will provide to achieve the outcomes called for in the RFP.
- These services should be consistent with the logic model that underlies program design.

Glossary of Acronyms for MHSA, PEI, and AOD

ADA	**Americans with Disabilities Act**
ADP	California Department of Alcohol and Drug Programs
ADPI	**Alcohol Drug Policy Institute**
AOD	Alcohol and Other Drugs
ASI	**Addiction Severity Index**
CDSS	California Department of Social Services
CFNLP	**California Friday Night Live Partnership**
CHHSA	California Health and Human Services Agency
CIMH	**California Institute of Mental Health**
CL	Club Live
CMDHA	**California Mental Health Directors Association**
CMHSCA	Center for Mental Health Services
COCE	**Center for Co-Occurring Excellence**
COD	Co-Occurring Disorders
COJAC	**Co-Occurring Joint Action Council**
CPI	Community Prevention Initiative
CSAP	**Center for Substance Abuse Prevention (federal)**
CSAT	Center for Substance Abuse Treatment (federal)
CSOC	**Children's System of Care**
DDCAT	Dual Diagnosis Capability in Addicts Treatment Index
DHCS	**Department of Health Care Services**
DHHS	Department of Health and Human Services
DMC	**Drug Medi-Cal**
DMH	Department of Mental Health
DPH	**Department of Public Health**
DSS	Department of Social Services
EBP	**Evidence Based Practice**
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FNL	**Friday Night Live**
FSP	Full Service Plan

FTE	**Full Time Equivalent (in reference to staff)**
FY	Fiscal Year
HIPAA	**Health Insurance Portability and Accountability Act**
HIV	Human Immunodeficiency Virus
IOM	**Institute of Medicine**
MHSA	Mental Health Services Act
MHSOAC	**Mental Health Services Oversight and Accountability Commission (created to monitor and direct MHSA)**
MOE	Maintenance of Effort
NADCP	**National Association of Drug Court Professionals**
NIATx	Network for the Improvement of Addiction Treatment
NIDA	**National Institute on Drug Abuse**
NIMBY	Not in My Backyard
NTP	**Narcotic Treatment Program (methadone program)**
OAC	Oversight Accountability Commission (see MHSOAC)
OCJC	**Office of Criminal Justice Collaboration (of ADP)**
OTP	Offender Treatment Program (similar to Prop. 36 programs)
PEI	**Prevention & Early Intervention (a component of MHSA)**
PTSD	Post-Traumatic Stress Disorder
PHI	**Protected Health Information**
RFP	Request for Proposal
SACPA	**Substance Abuse and Crime Prevention Act of 2000 (Proposition 36), cf. OTP**
SAMHSA	Substance Abuse and Mental Health Services Administration
SAP	**Student Assistance Program**
SBI	Screening and Brief Intervention
SBIRT	**Screening, Brief Intervention, Referral and Treatment**
SIR	Significant Issue Report
SIT	**State Interagency Team**
SMI	Serious Mental Illness/Seriously Mentally Ill
SPMI	**Severe Persistent Mental Illness**
TX	Treatment

References

The below are references for a variety of information related to AOD prevention and treatment plus specific MHSA resources, especially in helping develop PEI programs. Also see the Appendices.

PEI Webpage, MHSA website
http://www.dmh.ca.gov/Prop_63/MHSA/Prevention_and_Early_Intervention/default.asp

PEI Webpage, ADP website
http://www.adp.ca.gov/COD/pei.shtm

Proposed MHSOAC PEI Committee Action Plan for the First Three Years
http://www.dmh.ca.gov/MHSOAC/docs/Meetings/2008/Jan/FinalPEIPaperFirstThreeYears120707.pdf

Full Text of the MHSA
http://www.dmh.ca.gov/Prop_63/MHSA/docs/Mental_Health_Services_Act_Full_Text.pdf

MHSOAC Policy Direction for PEI
http://www.dmh.ca.gov/MHSOAC/docs/MHSOAC_PEI_PolicyDirection_07Sep9.pdf

SAMHSA's Co-Occurring Center for Excellence
http://coce.samhsa.gov/

SAMHSA's National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov

Treatment Improvement Exchange
http://www.treatment.org/topics/dual_documents.html

List of local mental health and behavioral health department MHSA county contacts
http://www.dmh.ca.gov/Prop_63/MHSA/docs/MHSACoCoordinatorListing.pdf

MHSA Coordinators' Monthly Statewide Calls (3rd Tuesday of most months, 2 - 3:00 PM): Tuesday, June 17, 2008; Tuesday, August 19, 2008; Tuesday, September 16, 2008; Tuesday, October 21, 2008; Tuesday, December 16, 2008

All conference calls will use the following call-in number and access code, unless otherwise specified: Conference Line – (605) 990-0300 • Access Code – 408008#

Appendices

The Appendices contain additional material regarding the MHSA's technical requirements for PEI programs.

Material relating to specific **evidence-based practices** and **programmatic guidance** can be found in Appendix 4, Enclosure 6 and in Appendices 1and 2.

Appendix 1 – ADP 09-27-07 Letter & Attachment on PEI Strategies for AOD Providers
http://www.adp.ca.gov/COD/pdf/PEI_Strategies.pdf

Appendix 2 – ADP Presentation on Accessing PEI Funding
http://www.adp.ca.gov/COD/pdf/PEI_for_COD_intro.ppt

Appendix 3 – DMH Information Notice 07-17 (PEI planning process guidelines)
http://www.dmh.ca.gov/DMHDocs/docs/notices07/07-17.pdf

Appendix 4 – DMH Information Notice 07-19 (PEI program and expenditure guidelines – especially Enclosure 6, "Resource Materials")
http://www.dmh.ca.gov/DMHDocs/2007_Notices.asp

Appendix 5 – I MHSOAC Proposal Review Tool
http://www.dmh.ca.gov/MHSOAC/docs/PEIReviewToolAdopted112107.pdf

Appendix 6 – Sample Budget and Service Plan Form (See attached Excel document.)

Appendix 7 – PEI-focused issue of the ADP-published *COD E-Circular*
http://www.adp.ca.gov/COD/documents.shtml